

The health status of women and children in Bangladesh

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Abstract:

This study attempts to investigate the utilization status of the government primary health care services on women and children in the rural areas of Bangladesh. Though there are a large number of indicators directly or indirectly related to the utilization status of health care services, we have chosen here to focus on some selected vital issues such as: knowledge of married women regarding health care facilities; knowledge on immunization; knowledge about appropriate time and doses for specific immunization; vaccination to youngest child and the place of vaccination; reasons for not giving vaccine to child/children; safety about immunization process; antenatal care; reasons for not visiting government hospital and finally the satisfaction of the respondent on govt. primary health care services. The study findings show a significant portion of the rural women does not participate in household decision making and about 69.3 percent of total women do not cast her vote independently. About 33.7 percent of rural women still believe in prejudice regarding health issues. About 35.0 percent of rural women being faced various type of social injustice.

Keywords- Health, Nutrition, Immunization, Mortality, Utilization.

1.1 Introduction

Health is defined as “A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”¹. Like other social sectors, health sector in Bangladesh is identified with poor and inefficient service delivery. Health is an important indicator of development of any country. To ensure an effective health care system that responds to the need of a healthy nation, a health policy provides the vision and mission for development. The overall health status of the people of Bangladesh is far below any acceptable standard. This is particularly true for the mothers and children who have the worst health statistics. For example, the maternal mortality rate is estimated to be 3.5 per 1000 live births, while infant (1<yr) mortality rate is 43 per 1000 live birth (**Bangladesh Economic Review-2008,p 164**). Child-bearing starts early and continues at frequent intervals, so maternal depletion syndrome is common in Bangladesh. The whole situation is further aggravated by ignorance of safe birth practices, poor socio-economic conditions and poor coverage and low utilization of the available health care facilities. Considering the alarming situation of the child health, the government of Bangladesh is implementing a number of priority programmes in the health sector since 1971. Bangladesh as member of the World Health Organization (WHO) and as a signatory of the “Alma-Ata Declaration” in 1978 was committed to achieve the goal of ‘Health for all by the year 2000 AD’ and to attain the goal of Primary Health Care (PHC) services was recommended as the key approach. The main objective of this approach was to improve the health status of population particularly mothers and children. Along with Bangladesh in most of the developing countries, it has been identified that, about one-third of the infant and child mortality can directly be attributed to the six vaccine preventable diseases: diphtheria, tetanus, ham, measles, polio and tuberculosis (UCIB, 1985). Thus, one-third of all child deaths can be prevented by providing immunization services to infants and tetanus toxin to prevent women. In view of this, the Government of Bangladesh launched the Expanded Programme of Immunization (EPI) on April 17, 1979. The Government of Bangladesh was committed to meeting the goal of Universal Child Immunization (UCI) by achieving 85 per cent coverage by 1990 and at least 90 percent coverage by 2000 through these intensive activities within the context of the primary health care structure and as a leading element of maternal and child health services. Most of people of Bangladesh cannot think proper health care service because they do not get proper food for their life leading. As a result, every year 320 women died per 100000 due to pregnancy related complication (NIPORT, 2003). Utilization of health services is a complex phenomenon, which is affected by factors such as availability, distance and cost, quality of care, social structure and health beliefs (**Becker et al., 1993**). Approximately 75% women die from a pregnancy related complication at home without any professional assistance (**Rahman et al., 1991**). **Akther (1993)** found that 14.8% respondents never had antenatal care during their last pregnancy. Only 9% deliveries are conducted by trained personals (**BIRPERHT, 1994**). So there has been growing concern that Bangladesh is facing persistent health crisis and the government, NGOs and international communities are striving hard to improve the poor health particularly maternal and child health.

¹ WHO

1.6 Objectives

What is the present status of utilization of government primary health care among married-women and children in rural areas of Bangladesh and what are the factors that influence the present status of utilization of govt. primary health care among married-women and children in the rural area of Bangladesh?

2.1 Literature review:

The state of primary health in a nation can be distinguished into mainly two wings such as maternal health & child health and further characterized by numerous factors, such as outcome measures like maternal mortality and morbidity rates, child mortality and morbidity rates, or maternal and child nutrition status, as well as process indicators of service availability and use. The government of Bangladesh has made considerable efforts to provide health and family planning services in the years since the country's independence in 1971, which has resulted in progress in some indicators. (A. R. Cross, and K. Jamil, 1997) For example, the national infant mortality rate (IMR) declined from 150 per 1000 live births in 1975 to 87 in 1999. The annual crude death rate has also fallen from 19 per 1000 in 1975 to just 5 in 2000. The annual birth rate declined from 43 per 1000 population in 1980 to 36 in 2000, giving a population growth rate of 1.7% in 2000, compared to 2.4% in 1980. This lowering of fertility is largely due to increases in the contraceptive prevalence rate (CPR), standing at 53.8% in 2000 (NIPORT, 2000).

The low level of ANC use in Bangladesh has remained virtually unchanged during the last five years. According to the DHS, use was 25.7% in 1993-94 and 26.4% in 1996-97. This low coverage is one of the most significant factors responsible for the high level of maternal mortality in Bangladesh (Bangladesh Ministry of Health and Family Welfare, 1999). In response to a question in the 1996-97 DHS, the vast majority of women responded that they felt ANC was beneficial (85%). This may imply that some other factors - perhaps cost or accessibility of services - accounts for the low ANC use, although a lack of women's decision-making power, multiple demands on women's time, and restrictions on women's movements during pregnancy have also been held as responsible (Mitra *et al.*, 1997; Rahman, 2000). Tetanus Toxoid (TT) vaccines are given during pregnancy for prevention of tetanus among newborns. Although there has been no change in recent years in ANC coverage, the proportion of pregnant women receiving TT injections has risen substantially. For births occurring in between 1992-96, 75% of mothers received at least one TT injection during pregnancy (Mitra *et al.*, 1997: 113), while by 1995-99; the proportion had increased to 81% (NIPORT, 2000).

The Bangladesh DHS (BDHS, 1999-2000) collected information from women about their perceived problems in accessing health care. 80% of women felt that not having a health facility nearby was an obstacle in accessing health care. 54% women mentioned lack of confidence in the service. Other problems often mentioned included: 71.4% difficulty getting money for treatment; 44% inability to get family permission; 49.2% difficulty to get someone to accompany them; 63.2% not knowing where to go. (BDHS, 2004) From the BDHS data, it would seem that distance and possible costs rate very highly in accessing health care when compared to other social barriers or perceived quality of care. The cost of maternal services present barriers to timely and appropriate care, both by delaying the choice to seek care, and by making some care completely inaccessible. In looking at hospital charges for maternal services in Dhaka, Nahar and Costello found that supposedly 'free' services involved substantial hidden costs, with 51% of families (74% of 42 those having caesarean sections) being unable to afford the service charges (Nahar and Costello, 1998). Bremmer and Van Den Broek also identify unaffordable costs, with 10 of 52 women agreeing that this was a factor in their refusal of referral (and only 6 actively disagreed with this reason) (Bremmer and Van Den Broek, 1995). A number of the studies discussed above mention a low perceived quality of care to be a factor influencing choice of service provision. In order to assess the quality of maternal health care services, a number of aspects can be analyzed including the structure, process and outcomes of services. (Roy, S. K, 2000) The process dimension is concerned with therapeutic and diagnostic procedures involved in providing services including interpersonal relations with the users. The outcome dimension can be seen to deal with change in maternal health status due to intervention, along with mother's satisfaction (Donabedian, 1966; Donabedian, 1980). Each of these factors affects the quality of services individually and collectively. The Bangladeshi Ministry of Health has stated that the quality of maternal health services provided by government institutions is below expectations. It suffers critically from a large number of problems, such as shortage of medical equipment, dearth of doctors/nurses/technicians, unhygienic physical environment, scarcity of power and water, pilferage of drugs and medicines and irregularities in the management system (Bangladesh Ministry of Health and Family Welfare, 2000).

2.2 Conceptual Framework:

Conceptual Framework has been developed on the basis of the review of literature of the utilization of the govt. primary health care. The conceptual framework primarily shows the descriptive analysis of numerous variables such as demographic variables, socioeconomic variables, knowledge about govt. primary health, and vaccination to child, place of vaccination, reason for not giving vaccine, reason for not visiting the govt. health care centre, satisfaction on govt. health care services, breastfeeding and social awareness, women participation on household decision as well as national concern.

Secondly, the conceptual framework shows the relationship between independent variables namely demographic, socio-economic, and cultural/ community. The dependent variable is namely the Antenatal care. The demographic factors are age of mother, religion and socio-economic factors are mother's education, mother's occupation. Community factor is distance of health facility.

Research Hypothesis:

In accordance with the theoretical framework and objectives of the study, the following hypotheses are formulated:

Hypothesis: 1 The awareness level of married women regarding health care services is up to the mark yet.

Hypothesis: 2 The utilization status of the govt. primary health care facilities is not satisfactory.

3.1 Study Objectives

3.1.1 General objective:

The main purpose of the study is to assess the awareness level and utilization status of the Government health care services of married women in the rural areas of Bangladesh.

3.1.2 Specific objectives

- to assess the awareness level of married women regarding various Government health care facilities;
- to review the utilization level of the health care facilities provided by the Government;
- to identify the reasons for not visiting Government health care centers available in the locality;
- to investigate the sources from where the married women get health service, and finally-
- to assess the social awareness of married women.

3.2 Study Design

This study is a cross-sectional study.

3.3 Target Population and Sample Population

The target population was all women who are in the reproductive age group in Kushtia Sadar Upazila. The sample population was all such women who are married and who had given birth to at least one child in last five years in this region. As cluster sampling method is used, women living in the clusters in this area are interviewed as per the eligibility dictated by exclusion and inclusion criteria.

3.4 Study Area

Rural areas of Kushtia sadar upazila of the Kushtia district excluding the municipality areas.

3.5 Study Period

The study period is from June 2011 to August 2011

3.7 Sampling Techniques and Size of Sample

We adopted a single-stage cluster sampling design because of its principle of simplicity, low cost, quick and ease of operation. Primarily, information was collected from Civil Surgeon Office-Kushtia and Kushtia Sadar Thana Health Complex regarding the programme performance status of the 10 villages of kushtia. From the official record we were informed that there were no significant high or low performing villages among the 25; further that all of them were officially treated as average performing villages. Using the single-stage cluster sampling technique, we divided the total 10 villages into five different clusters (geo-graphical area) each of them having two villages. Then we randomly selected one village from each of the clusters. After selecting five villages, we covered all the married women between the age ranges of 15 to 49 years and finally we got a total sample of 300 married women. The sample of the study is the number of women in the reproductive age group who gave birth to at least one child in last five years before the start of the study.

3.8 Data collection, Management and Analysis Plan

In-depth interview through individual questionnaire for women is used for collection of information. The total questions are prepared and printed. A written informed consent is taken from all the persons involved. All answers are either yes-no or requires single word. Answers are coded as required. Anyone could skip any question that one liked. All interview questionnaires are checked for their internal consistency to exclude missing or inconsistent data. Data is entered in data file using statistical software called SPSS (statistical package for social science). Data is analyzed statistically. Frequency distribution and descriptive statistics are used to explore background characteristics in the sample population such as the demographic, socio-economic and other factors related to institutional delivery. Bi-variate analysis such as cross tabulation and chi-square analysis is used to determine the relationship between dependent and independent variable. For all analysis the statistical package for social science is extensively used. All the factors are calculated individually and also holistically. Results are also laid with prevalence rate, frequency distribution and chi square test, Fisher's exact test and other statistical tests.

Findings of the Study

4.1 Results and Discussion

The main target of this paper is to evaluate the awareness level and utilization status of the Government's health

care services especially of the married women in the rural areas of Bangladesh. Although there are a large number of indicators directly or indirectly related to awareness level of married women and utilization status of the Government health care services, we have chosen here to focus on some selected crucial aspects. These identified aspects are: socioeconomic condition of the respondent, knowledge of married women regarding health care facilities; knowledge on immunization; knowledge about appropriate time for specific immunization; vaccination to youngest child and the place of vaccination; reasons for not giving vaccine to children, antenatal care, reasons for not visiting Government health care centers and finally examines the social awareness level of the respondent such as; whether she knows that access to basic health is her fundamental right, whether she knows the name of Union Parishad Chairman, whether she cast vote in her own choice, whether she take part in household decision making, whether she face any injustice from the family and protest against injustice and finally whether she believe in prejudice regarding health matter. In accordance with the objectives and identified indicators the findings of the study have been presented by the following sections:

Section 4.2 knowledge of married women regarding Government health care facilities;

Section 4.3 focuses on mother's knowledge about immunization;

Section 4.5 briefs about vaccination to youngest child and the place of vaccination;

Section 4.7 briefs about utilization of the antenatal care by government among the married women;

Section 4.8 briefs the causes for not visiting govt. health care centre in the locality, and finally-

Section 4.9 briefs about social consciousness and empowerment of married women in the study area.

4.3 Knowledge on Health Care Facility

To evaluate respondent's knowledge about Government's health care services that are available in their locality respondents were asked about some selected aspects. In response to the question whether they had heard of or know any of the health care centers at their union/area, about 81.0% percent reported that they were aware of health care centers in their locality which provided different types of health services (table-10;). This knowledge was found to be higher (61.7%) among the married women (age group 21-34 years) than married women (age group 35-49) counterparts (12.3%).

4.3.1 Knowledge about Health Care Facility Available in the Locality

Table-10 reveals that about 81.0 percent of the total women know any health care centers available in the locality. On the other hand about 19.0 percent women did not aware of this regarding issues.

Table-10; Knowledge about Health Care Facility Available in the Locality (Actual & percentages)

Knows about govt. health care in the locality		Age group			Total
		Age< 20	Age 21-34	Age 35-49	
yes	Count	21	185	37	243
	% within Age group	77.8%	85.3%	66.1%	81.0%
	% of Total	7.0%	61.7%	12.3%	81.0%
no	Count	6	32	19	57
	% within Age group	22.2%	14.7%	33.9%	19.0%
	% of Total	2.0%	10.7%	6.3%	19.0%
Total	Count	27	217	56	300
	% within Age group	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011.

In the age group below 20, among 27 respondents 6 (22.2%) of them reported that, they do not knows about govt. health care centre in the locality. The significant portion of the respondents 32 (14.7%) within (21-34) age group reported that, they do not knows the govt. health care in the locality. About 81.0 percent women know about govt. health care centers are available in the locality. So, the above analysis shows that the awareness level of the respondent regarding health care facility is up to the mark. Thus null hypothesis is accepted.

4.3.2. Knows the Name of Health Care Centre Available in the Locality

Table-11 reveals that at aggregate level, about 59.0% of the respondents could mention the name of at least one health care center in the locality. Out 300 respondent, 123 (41.0%) of the respondent does not knows the name of at least one health care centre in the locality. However, in this study, no attempt was made to ascertain how far this knowledge was effective in terms of correct knowledge about the name of health care centers and the services provided from these centers.

Table-11; Knows the Name of Health Care Centre Available in the Locality (Actual & percentages)

Knows the name of health care centre in the locality		Age Group			Total
		Age <20	Age 21-34	Age 35-49	
yes	Count	16	132	29	177
	% within Age Group	59.3%	60.8%	51.8%	59.0%
	% of Total	5.3%	44.0%	9.7%	59.0%
no	Count	11	85	27	123
	% within Age Group	40.7%	39.2%	48.2%	41.0%
	% of Total	3.7%	28.3%	9.0%	41.0%
Total	Count	27	217	56	300
	% within Age Group	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011.

At aggregate level, about 59.0 percent women know at least on health centre in the locality. This is not at standard level. Therefore, the null hypothesis of awareness level of married women regarding health care services is up to the mark is rejected.

4.3.3 Knows the Service Delivered by the Health Care Centre in the Locality

Table-12; reveals that, interestingly slightly higher proportion of women (60.7%) could mention the name of services delivered from the health care centers. The table 4.3.3 also reveals that 118(39.3%) respondent's do not knows the services delivered by the health care centre in the locality. The respondent who's age below 20 is less aware than age group 21-34, 5.0% (below 20) < 44.3% (age group 21-34). Only 60.7 percent of total women know at least one service delivered by govt. health care centre available in the locality, which is not at standard level. Thus the null hypothesis of awareness level of married women regarding health care services is up to the mark is rejected.

Table-12; Knows the Service Delivered by the Health Care Centre in the Locality (Actual & percentages)

Knows the service delivered by the health care centre in the locality		Age Group			Total
		Age <20	Age 21-34	Age 35-49	
yes	Count	15	133	34	182
	% within Age Group	55.6%	61.3%	60.7%	60.7%
	% of Total	5.0%	44.3%	11.3%	60.7%
no	Count	12	84	22	118
	% within Age Group	44.4%	38.7%	39.3%	39.3%
	% of Total	4.0%	28.0%	7.3%	39.3%
Total	Count	27	217	56	300
	% within Age Group	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011.

4.3.4 Whether utilize govt. health care facility in the locality

Table-14; reveals that 61.7 percent of the total married women utilized health care services provided by the government within the locality. Older age group was keener to utilize this service than younger women. About 38.3 percent of total women did not utilize these facilities.

Table-13; whether the respondent utilizes govt. health care services in the locality

Whether utilize govt. health care facility		Age Group			Total
		Age<20	Age 21-34	Age 35-49	
no	Count	12	87	16	115
	% within Age Group	44.4%	40.1%	28.6%	38.3%
	% of Total	4.0%	29.0%	5.3%	38.3%
yes	Count	15	130	40	185
	% within Age Group	55.6%	59.9%	71.4%	61.7%
	% of Total	5.0%	43.3%	13.3%	61.7%
Total	Count	27	217	56	300
	% within Age Group	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011.

This figure is much lower than that of the findings of the study conducted by Kamal et. al. in 1992 on the Grameen Bank beneficiaries (64 percent). Thus there is a big gap between prevailing knowledge and ever use of health care facilities available in the locality. Thus, the null hypothesis is rejected, i.e. the awareness level of married women regarding health care services is not up to the mark yet.

4.4 Mothers' Knowledge on Immunization

Mothers awareness regarding immunization for children and their knowledge of the appropriate age range of children at which specific immunization should be given are the most important indicators for measuring the utilization level of the Government health care programmes. In this study, attempts were made to examine whether the mothers were aware of immunization and whether they knew the appropriate time of vaccination to their children. To evaluate the general knowledge of immunization, the respondents were asked whether they had heard about immunization in general. Data on knowledge of immunization were collected using the structured questionnaire through recall method. The overall knowledge was taken into consideration by combining prompted and unprompted knowledge. Knowledge about immunization was assessed through asking the respondents, the name of the diseases preventable by the vaccine. Table: 5.3 represent the percentages of married women who were aware of any of the vaccine for immunization.

The findings of the study (Table: 5.3) indicate that among the individual vaccines, Measles/Ham was known to the highest proportion (98.3%) of the respondents, followed by Polio (97.3%), TT (94.0%), DPT (56.0%), BCG (49.3%), Hepatitis B (30.7%) and pentavolen (3.0%).

Table-14; Proportion of the Married Women in terms of Awareness of Different Vaccines (Actual & percentages)

Sl. No	Name of Vaccine	Awareness Level (Actual & percentages)			
		Age <20	Age 21-34	Age 35-49	Total
1	TT	27 (100.0%)	206 (94.9%)	49 (87.5%)	282 (94.0%)
2	DPT	13 (48.1%)	127 (58.5%)	28 (50.0%)	168 (56.0%)
3	Polio	27 (100.0%)	210 (96.8%)	55 (98.2%)	292 (97.3%)
4	BCG	19 (70.4%)	101 (46.5%)	28 (50.0%)	148(49.3%)
5	Measles/Ham	27 (100.0%)	212(97.7%)	56 (100.0%)	295 (98.3%)
6	Hepatitis B	4 (14.8%)	83 (38.2%)	5 (8.9%)	92 (30.7%)
7	Pentavolen	0 (0.0%)	9 (4.1%)	0 (0.0%)	9 (3.0%)
8	Total	N=27	N=217	N=56	N=300

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011.

The awareness level about the vaccine namely TT, Polio and Measles are satisfactory and thus our null hypothesis of awareness level of married women regarding health care services is up to the mark is accepted.

On the other hand in case of vaccines like DPT, BCG, and HepB, only 56.0 percent of total women know the name of DPT, 49.1 percent and 30.7 percent knows the name of BCG and HepB respectively. These findings are not satisfactory with standard level. So the null hypothesis regarding this issue is rejected.

4.7 Reasons for Not Giving Vaccine to the Youngest Child

Although already it has been found that majority of the married women (90 percent) immunized their children, yet about eight percent of them denied having immunization for their children. In response to the question why they had not immunized their children, a variety of causes they mentioned. The distribution of married women

along with their responses for which they had not immunized their children has been shown in Table-18; it has been shown that lack of effective knowledge about vaccine appeared as the most important factor (70.0%) for not giving vaccine to their children. In adequate supply of vaccine from the vaccinator side (16.7%), far distance of vaccination centre (8.3%), no faith on vaccination (4.2%) were other vital reasons. Thus to increase the immunization coverage, knowledge about immunization and its impact on child health should be increased further among the rural married women through designing appropriate educational and training programme.

Table-17; Proportion of the Respondents by Main Reasons for not giving Vaccine to the Youngest Child

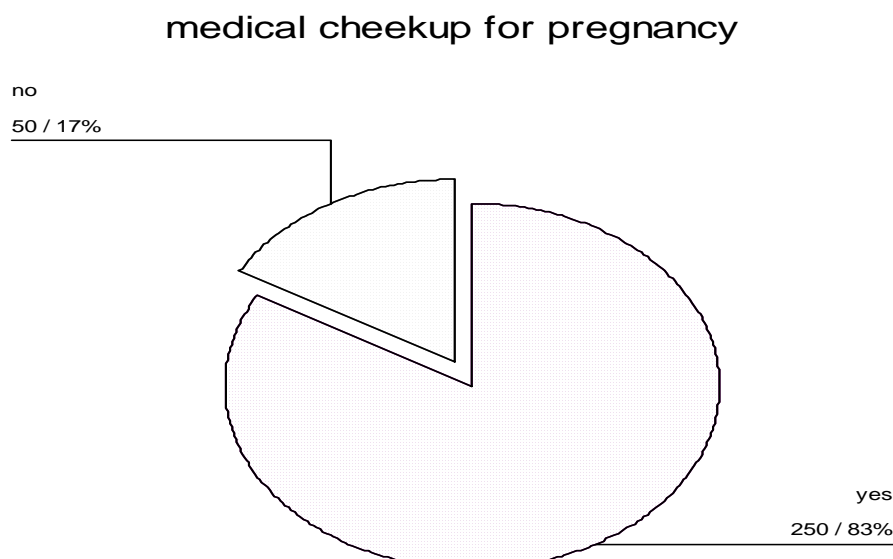
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Lack of effective knowledge about vaccine	17	5.7	70.8	70.8
	No faith on vaccine	1	.3	4.2	75.0
	Far distance of vaccination centre	2	.7	8.3	83.3
	In adequate supply of vaccine	4	1.3	16.7	100.0
	Total	24	8.0	100.0	
Missing	Not Applicable	276	92.0		
Total		300	100.0		

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011

4.8.1 Utilization of antenatal care

Among all the mothers 83.0% mothers did receive antenatal care in present or past pregnancies. Here receive means one or more times. WHO standard of 13 visits or the minimum 4 visits is not taken into account because then the prevalence goes down significantly as is revealed during the interview sessions. 17.0% did not receive any antenatal care.

Figure-3; Antenatal care utilization among the mothers in last two years



Yes indicate that the mother did receive at least one antenatal care visit.

4.8.2 Ante natal care and demographic factors

Antenatal care utilization is compared with demographic factors. The factors are maternal age group, classified into 3 groups; the first one is with age below 20 years of which 81.5% received antenatal care; the second group contains women in age range of 21- 34 years of which 77.4% received antenatal care, the third group contains

older women aging beyond 35years. Here 55.4% received antenatal care. The association between the demographic factor (age of women) and the utilization of ante natal care is found out by doing the Pearson's Chi-Square test. The association between demographic factor and utilization of ante natal care is found statistically highly insignificant at 5% level. The results are shown in the following table.

Table-19; Bi-variate analysis: Antenatal care and demographic factor (age of women)

		Antenatal Care		Total	P value
		yes	no		
Age< 20	Count	22	5	27	.748 ¹
	% within Age group	81.5%	18.5%	100.0%	
Age 21-34	Count	183	34	217	
	% within Age group	84.3%	15.7%	100.0%	
Age 35-49	Count	45	11	56	
	% within Age group	80.4%	19.6%	100.0%	
Total	Count	250	50	300	
	% within Age group	83.3%	16.7%	100.0%	

¹* Pearson's Chi-Square Test

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011

4.8.3 Ante natal care utilization and socio-economic factors

Antenatal care utilization is compared with socio-economic factors. The factors are maternal education and maternal occupation. Maternal education is classified into five groups; no education, primary education, secondary education, higher secondary education and graduation. Among mothers 91% mothers with no education, 82% mothers with primary education, 67% mothers with secondary education, 80% mothers with higher secondary education and 60% mothers with higher degrees obtained antenatal care. The last factor analyzed is maternal occupation which is consisted of three groups, namely housemaid, housewife, and service holder. 85.7% of housemaid utilizes antenatal care; figures are 81.6% and 100% respectively for the rest of two groups. Pearson's Chi-Square test is done to find out statistical significance at 5% (chi-value 13.443) and all two factors show statistically significant association with the utilization of ante natal care. Thus the null hypothesis of the utilization status of the govt. primary health care facilities is not satisfactory is rejected and alternative hypothesis should be accepted.

Table 20; Bi-variate analysis: Antenatal care and socio-economic factors

Socio-economic Factors	Ante Natal Care Utilization (Actual and Percentage)			Grand Total (N)	p value
	Yes	No	Total		
Mother's Education					
Illiterate	101(91.0)	10(9.0)	111(100)	111	0.0090 ¹
Primary Education	109(82.6)	23(17.4)	132(100)	132	
Secondary Education	25(67.6)	12(32.4)	37(100)	37	
Higher Secondary	12(80.0)	3(20.0)	15(100)	15	
Graduation	03(60.0)	02(40.0)	5(100)	05	
Maternal Occupation					
Housemaid	6(85.7)	1(14.3)	7(100)	7	0.049 ¹
Housewife	217(81.6)	49(18.4)	266(100)	266	
Service holder	27(100)	00(00.0)	27(100)	27	

¹Pearson's Chi-Square Test

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011

4.8.5 Ante natal care utilization and community factors

Antenatal care utilization is compared with community factors. The factors are distance from health facility, pays little attention by the duty persons, misbehavior, non availability of medicine, and others.

Table-21; Bi-variate analysis: Antenatal care and community factors

Community Factors		Antenatal care			P Value
		yes	no	Total	
Far distance	Count	64	23	87	0.171*
	% within Not Visit	73.6%	26.4%	100.0%	
	% within Antenatal	29.0%	29.1%	29.0%	
	% of Total	21.3%	7.7%	29.0%	
Pays little attention	Count	48	8	56	
	% within Not Visit	85.7%	14.3%	100.0%	
	% within Antenatal	21.7%	10.1%	18.7%	
	% of Total	16.0%	2.7%	18.7%	
Misbehavior	Count	70	33	103	
	% within Not Visit	68.0%	32.0%	100.0%	
	% within Antenatal	31.7%	41.8%	34.3%	
	% of Total	23.3%	11.0%	34.3%	
Mon availability of medicine	Count	36	13	49	
	% within Not Visit	73.5%	26.5%	100.0%	
	% within Antenatal	16.3%	16.5%	16.3%	
	% of Total	12.0%	4.3%	16.3%	
Others	Count	3	2	5	
	% within Not Visit	60.0%	40.0%	100.0%	
	% within Antenatal	1.4%	2.5%	1.7%	
	% of Total	1.0%	.7%	1.7%	
Total	Count	221	79	300	
	% within Not Visit	73.7%	26.3%	100.0%	
	% within Antenatal	100.0%	100.0%	100.0%	
	% of Total	73.7%	26.3%	100.0%	

* Pearson's Chi-Square Test

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

The above table reveals that total 73.7 percent of total married women having antenatal care and remaining 26.3 percent did not having antenatal care at all. Among them about 21.30% percentage of mothers having ante natal care but did not visit to the govt. health care centre for the reason of far distance and remaining 23.3%, 16.0%, 12.0%, and 1.0% did not visit for the reason of misbehavior, pays little attention, non availability of medicine and others respectively. Pearson's Chi-Square Test is done and statistically insignificant at 5% level of significance association in this case. Therefore the null hypothesis of the utilization status of the govt. primary health care facilities is not satisfactory is accepted.

4.9 briefs the causes for not visiting govt. health care centre in the locality

Question asked to that women who have already utilized govt. health facilities or not and want to know why they did not visit to the govt. health care centre in the locality. About 29.0 percent women reported that because of long distance they are reluctant to visit govt. health care centre. Highest proportion of women 103(34.3%) argued that the responsible person act misbehave with them, so they do not take visit for health care services in govt. health care centre. Another 56(18.7%) women reported that they always pays little attention to the visitor who need health care services as a result they did not visit govt. health care centre. Many of them reported that, sometimes the duty doctors in the govt. health are likely to be ignoring poor person and they give preferences local leader, nephew or comparatively rich person. About 16.3 percent married women reported that doctors, midwives or duty nurse often said they don't have available medicine to care them.

Table-22; Reason for not visiting the govt. health care center in the locality

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid far distance	87	29.0	29.0	29.0
pays little attention	56	18.7	18.7	47.7
misbehavior	103	34.3	34.3	82.0
non availability of medicine	49	16.3	16.3	98.3
others	5	1.7	1.7	100.0
Total	300	100.0	100.0	

Source: field survey on 300 married women, Kustia Sadar Upazila, Kushtia, 2011

4.11 Women Social Status in the Study Area

Utilization of government health care facility also depend on the some important factors such as involvement of women in household decision making, does women believe in prejudice regarding health condition. Beyond of this factor we also map out some important indicators that measure women status in the society, such as is she faces any injustice from the family, protest against injustice and cast her vote deliberately to her chosen person.

4.11.1 Knowledge on health right

Access to health care facilities is a basic right for every citizen of a country. It is an obligatory responsibility of the government to ensure health care facilities for all the citizen of the country. With the view of that sense we try to map out the actual scenario of the studied women that how much awareness they have about health right. About 69.3 percent married women know that access to basic health is their fundamental right. On the other hand, 30.7 percent married women do not know that access to basic health is their fundamental right. This result is presented in the following table-23;

Table-25; Respondent's knowledge about health right

Do you know that access to basic health is your fundamental right?		Age Group			Total
		below 20	21-34	35-49	
yes	Count	20	147	41	208
	% within Age Group	74.1%	67.7%	73.2%	69.3%
	% of Total	6.7%	49.0%	13.7%	69.3%
no	Count	7	70	15	92
	% within Age Group	25.9%	32.3%	26.8%	30.7%
	% of Total	2.3%	23.3%	5.0%	30.7%
Total	Count	27	217	56	300
	% within Age Group	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

4.11.3 Women participation in vote casting

According to the Constitution of Bangladesh, women have equal rights with men in all spheres of the State and public life [Article 28(2)]. Even so, our constitution gives full of joy and freedom for women to take part in all activities for the state as well as herself, notwithstanding the real picture does not shows that fact, table-25; reveals that about 69.3 percent of total women did not cast vote her own chosen candidate, they were partially or fully motivated by their husband, father, or others. About 30.7 percent married women did her vote in own chosen candidate. Among three aged group, older aged women are more fearless than younger married women in casting vote.

Table-27; Respondent's freedom in case of vote casting

Cast vote for own chosen candidate		Age Group			Total
		below 20	21-34	35-49	
yes	Count	7	61	24	92
	% within AGE GROUP	25.9%	28.1%	42.9%	30.7%
	% of Total	2.3%	20.3%	8.0%	30.7%
no	Count	20	156	32	208
	% within AGE GROUP	74.1%	71.9%	57.1%	69.3%
	% of Total	6.7%	52.0%	10.7%	69.3%
Total	Count	27	217	56	300
	% within AGE GROUP	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

4.11.4 Women participation in household decision making

Women's rights to equality and affirmative action in respect to equality are guaranteed in the Constitution. According to the Constitution of Bangladesh, all citizens are equal before the law and are entitled to equal protection of the law (Article 27); the State shall not discriminate against any citizen on the grounds of religion, race, caste, sex or place of birth [Article 28(1)]; women have equal rights with men in all spheres of the State and public life [Article 28(2)]; nothing shall prevent the State from making special provision in favour of women or for the advancement of any backward section of the population [Article 28(4)].

The Constitution further advances and incorporates the principle of special representation of women in local self-governing bodies (Article 9). Three women members are elected to the Union Parishads and Municipal Councils. Provision has also been made to reserve thirty seats for women in the Parliament (Article 65). Notwithstanding, the women of our country are more vulnerable in many aspects, they did not play vital role for their family decision making, they always dominated by their respective persons.

Table-28; Women participation in household decision making

Household decision making		Age Group			Total
		below 20	21-34	35-49	
yes	Count	9	51	12	72
	% within AGE GROUP	33.3%	23.5%	21.4%	24.0%
	% of Total	3.0%	17.0%	4.0%	24.0%
no	Count	18	166	44	228
	% within AGE GROUP	66.7%	76.5%	78.6%	76.0%
	% of Total	6.0%	55.3%	14.7%	76.0%
Total	Count	27	217	56	300
	% within AGE GROUP	100.0%	100.0%	100.0%	100.0%
	% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

Table-26; reveals that, about 76.0 percent of total women did not participate in household decision making and only 24.0 percent women take part in household decision making. This picture took from rural areas and gives us an idea about aggregate level.

4.11.5 Injustices faced by the women

Women faced injustice from their family. Their husband either torture mentally or physically, even they were lost their right from the family properties. About 35.0% of women were victimized by their husband or others

member from their family. The table-27; reveals that age group 21-34 were more victim of family injustice than others two age groups. About 65.0% women reported that they did not face any types of misbehavior or injustice from their family.

Table-29; Injustices faced by the women

Injustices faced by the women			Age Group			Total
			AGE<20	AGE 21-34	AGE 35-49	
Age Group	yes	Count	3	89	13	105
		% within Age Group	11.1%	41.0%	23.2%	35.0%
		% of Total	1.0%	29.7%	4.3%	35.0%
	no	Count	24	128	43	195
		% within Age Group	88.9%	59.0%	76.8%	65.0%
		% of Total	8.0%	42.7%	14.3%	65.0%
Total		Count	27	217	56	300
		% within Age Group	100.0%	100.0%	100.0%	100.0%
		% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

4.11.5 Women's believe in prejudice

This is the common phenomena in rural areas of Bangladesh, that they believe evil spirits or evil's soul regarding health issues. They think evil's has power to deteriorate child health or mother health. Consequently they were used to meet Kabiraj or Fakir to remedy of their health condition. They spent lots of money and time for this purpose.

Table-30; Believe in prejudice by the respondent

Believe in prejudice			Age Group			Total
			AGE<20	AGE 21-34	AGE35-49	
no		Count	16	142	41	199
		% within Age Group	59.3%	65.4%	73.2%	66.3%
		% of Total	5.3%	47.3%	13.7%	66.3%
	yes	Count	11	75	15	101
		% within Age Group	40.7%	34.6%	26.8%	33.7%
		% of Total	3.7%	25.0%	5.0%	33.7%
Total		Count	27	217	56	300
		% within Age Group	100.0%	100.0%	100.0%	100.0%
		% of Total	9.0%	72.3%	18.7%	100.0%

Source: Field Survey on 300 Married Women, Kustia Sadar Upazila, Kushtia, 2011

About 33.7 percent of total women reported that they strongly believe in prejudice or evil's spirits for deteriorating health condition as well as improving health condition. For this reason Government health care policies some time does not work properly in rural area. Table-28; shows that about 66.3 percent women do not believe in prejudice. They have no faith on Kabiraj or Fakir for remedy of their health condition.

5.1 Conclusion

The present study used the field survey data to analyze certain selected issues regarding utilization level of Government health care facilities by married women in the rural areas of Bangladesh. Based on study findings this section provides a brief discussion and concluding remarks. The knowledge about Government health care centers as well as type of health facilities available there is relatively poor among married women within the study area.

In the treatment of sickness, a significant proportion of the rural mothers still rely on the rural quacks despite the availability of qualified Government physicians in the health care centers. Our study identified two main factors resulting in the services being out of reach for many rural women: First, the culturally defined limitations on rural women's mobility, and the second one is the large working areas of these centers. Government should take

appropriate measures to enhance the confidence of the rural women as well as their husbands and other matured family members on modern health care facilities through motivation, health education and improved quality of care. Along with parents appropriate functional education should be provided to the community leaders.

Finally, proper steps should be taken to bring the health care services at the doorstep of the rural women. For that the number of health care centers can be increased so that the health care facilities come within the reach of the rural women. Measures should be taken to arrange mobile clinics within the short distance in the heavily populated area as well as steps should be taken to ensure home visits by the Government health personnel.

References:

1. Uddin, Kamal. and Bhuiya. Alamgir. (2003). "Utilization of the Government Health Care Services: A Study on Married Adolescents in Rural Bangladesh." *The Islamic University Studies*, Part-C
2. Akther, H. H. (2003). Baseline survey for assessment of EOC services in Bangladesh. Bangladesh Institute for Promotion of Essential and Reproductive Health Technologies (BIRPERHT), Dhaka.
3. Akther, H. H. *et al.* (2006). A cross-sectional study on maternal morbidity in Bangladesh. Bangladesh Institute for Promotion of Essential and Reproductive Health Technologies (BIRPERHT), Dhaka.
4. Bangladesh Bureau of Statistics (2009), Statistical Pocket Book. Ministry of planning, Dhaka.
5. Bangladesh Bureau of Statistics (2000). Statistical Pocket Book. Ministry of Planning, Dhaka.
6. Bangladesh Director General of Health Services (2009). Bangladesh Health Services Report. Dhaka.
7. Bangladesh Ministry of Health and Family Welfare (September 1993), the National FPMCH Strategy for Bangladesh 1993-2000. Dhaka.
8. Bangladesh Institute of Research for Promotion of Essential & Reproductive Health and Technologies (BIRPERHT), (1995). Baseline Survey for Assessment of Emergency Obstetric Care Services in Bangladesh, Dhaka.
9. Donabedian, A. (2006). "Evaluating the quality of medical care." *Milbank Memorial Quarterly*, **44**, pp. 166-203.
10. Donabedian, A. (2010). "Institutional and professional responsibilities in quality assurance." *Quality Assurance in Health Care in vulnerable pregnant women*, **1**(1), pp. 3-11.
11. Mitra, S. N., A. Al-Sabir, A. R. Cross, and K. Jamil (1997). Bangladesh Demographic and Health Survey 1996-1997. Dhaka and Calverton, Maryland: National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International, Inc.
12. Nahar, S. and A. Costello (1998). "The hidden cost of 'free' maternity care in Dhaka, Bangladesh." *Health Policy and Planning*, **13**(4), pp. 417-422.
13. Roy, S. K. (2000). Pattern of health seeking behavior of rural households in Bangladesh. M Phil (PSM) Session 1998-2000. National Institute of Preventive and Social Medicine (NIPSOM), Dhaka.
14. Bremmer, M. and G. Van Den Broek (1995)7. Refusal for referral among pregnant women in the MCH-FP area Matlab: July 1993 - July 1994. Student Report, University of Amsterdam.

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